

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Fair Hearing Request of:

ADAM W.

Claimant,

vs.

FRANK D. LANTERMAN REGIONAL
CENTER,

Service Agency.

OAH Case No. L2005060532

DECISION

Robert S. Eisman, Administrative Law Judge, State of California, Office of Administrative Hearings, heard this matter at the Frank D. Lanterman Regional Center in Los Angeles, California, on January 20 and 26, 2006.

Pat Huth, Attorney at Law, represented the Frank D. Lanterman Regional Center (FDLRC or service agency).

N. Jane DuBovy, Attorney at Law, represented the parents of Adam W. (claimant).¹ Roseanne W., claimant's mother, was present during the entire hearing. Richard W., attended the hearing only on January 20, 2006.

The service agency and claimant offered documents and sworn testimony, and argued the case.

The parties' closing arguments were marked for identification as part of the record as follows:

¹ Claimant and members of claimant's family are referred to by their first names and the first initial of their last names to protect the claimant's privacy. Claimant's relatives are also identified by their relationship to claimant.

<u>Document</u>	<u>Marked for Identification as</u>
Service Agency Closing Brief	SA-23
Service Agency Closing Rebuttal Brief	SA-24
Claimant's Closing Brief	C-16
Claimant's Reply Brief	C-17

The record was left open for each party to submit written closing argument no later than February 14, 2006 and written rebuttal argument no later than February 28, 2006. The record was then closed. The Administrative Law Judge completed his review of all briefs on March 6, 2006, and the matter was deemed submitted on that date.

The Administrative Law Judge makes the following factual findings, legal conclusions and order:

ISSUES

Claimant is a nine-year-old male consumer of the Frank D. Lanterman Regional Center who is eligible for service agency services based on a diagnosis of autism. Claimant lives at home with his parents and has a 19-year-old sister. Claimant participates in an education program at Rosewood Elementary School, Los Angeles Unified School District (LAUSD), where he is currently mainstreamed in a regular third grade class. During the school day claimant is accompanied by a one-to-one support aide. Prior to July 2005, claimant had been authorized by the service agency to receive six (6) hours of discrete trial training per week. As of July 2005, that amount was reduced to four (4) hours per week. Claimant is not receiving any applied behavior analysis or behavioral intervention services through LAUSD. Claimant appealed the service agency's reduction in discrete trial training hours and desires to receive applied behavioral analysis/discrete trial training at the rate of 10 hours per week. Claimant contends that compensatory applied behavioral analysis/discrete trial training should be allocated at the rate of two hours per week for the period since July 2005, based on the premise that services should have been continued at six hours per week, pending claimant's appeal.

The parties agree that the following issues are to be resolved:

1. Should the service agency fund up to 10 hours per week of direct intervention applied behavior analysis/discrete trial training for claimant?
2. What portion, if any, of claimant's funded applied behavior analysis/discrete trial training, should be allocated to parent training?

3. Is claimant entitled to compensatory applied behavioral analysis/discrete trial training based on the service agency reduction in this service from six to four hours per week, commencing in July 2005?

EVIDENCE RELIED UPON

- A. Service agency exhibits SA-1 through SA-22, which were admitted into evidence.

Service agency exhibits SA-23 and SA-24 are the service agency's closing brief and closing rebuttal brief, respectively, which were only marked for identification.
- B. Claimant exhibits C-1 through C-15, which were admitted into evidence.

Claimant's exhibits C-16 and C-17, which are claimant's closing brief and reply brief, respectively, which were only marked for identification.
- C. Testimony of Roseanne W., claimant's mother.
- D. Testimony of Mandana Moradi, Psy.D., a clinical psychologist under contract to FDLRC. Dr. Moradi also has a private practice that focuses on autistic children.
- E. Testimony of Jean Johnson, Ph.D., a clinical specialist under contract to FDLRC to review programs.
- F. Telephonic testimony of Audry E. Griesbach, M.D., a pediatrician who specializes in the treatment of children with neuro-developmental disorders.
- G. Testimony of Sam Suzuki, the FDLRC regional manager for Los Angeles school-age children. Mr. Suzuki is claimant's regional manager.
- H. Testimony of Jessye Davis, FDLRC service coordinator. Ms. Davis is claimant's service coordinator.

FACTUAL FINDINGS

1. Claimant is a nine-year-old male (date of birth: February 1, 1997) consumer of the service agency who is eligible for services based on a diagnosis of autism². Claimant is hyperactive and has a seizure disorder.

² The clinical diagnosis of autism is based on findings of emotional detachment, extreme interpersonal isolation, little if any toy or peer play, language disturbance (mutism or echolalia), excessive rituals, and onset in infancy.

2. Claimant is a "high functioning" and gifted child. He functions academically on a par with non-developmentally disabled children, as demonstrated by his achievements/grades in a mainstream third-grade class at his regular public school. Claimant also is gifted with respect to his musical talents, as evidenced by his accomplishments as a cellist.

However, claimant exhibits characteristics of autism that have an impact on his ability to communicate, socialize, and behave appropriately. He has significant deficits pertaining to toilet training, aggression, non-compliance, and tantrums. Some of claimant's inappropriate and self-injurious behaviors directly relate to his well-being and safety. Claimant's mother is concerned about his behavior in the non-school environment, and his aggressiveness towards her, especially now that he is getting bigger.

3. From 2001, when claimant first became a client of the service agency, and continuing until the present time, the service agency had authorized funding of what has variously been called "applied behavior analysis," "discrete trial training," and "behavior modification." Unfortunately, the parties in this matter have confused what these various terms mean, resulting in miscommunications and misunderstandings between the parties.

4. Applied Behavior Analysis (ABA), is an intervention for the treatment of autism. It is often associated with specific behavioral methods, such as: discrete trial training, which is sometimes also called "Lovaas" therapy or the Lovaas method; intensive behavioral intervention; incidental teaching; pivotal response training; and verbal behavior analysis.

The method and technique of ABA therapy requires that targeted behaviors be reduced to their most basic elements, and that the subject then be trained by repetitious drilling in the redirected behaviors desired. Contextual factors, established operations, antecedent stimuli, positive reinforcers, and other consequences are used, based on identified functional relationships between the subject and the environment, in order to produce practical behavioral change. Negative behaviors are generally ignored; if aversive treatment is called for, it is minimal, consisting of repetitious utterances of the word "no" and possibly physical contact between the instructor and the subject. Prompts or other assistance are timed and provided to assure correct responses, and then gradually "faded" to establish independence. The subject is then urged to repeat each task until it has been learned.

5. Discrete Trial Training (DTT) is one of the instructional methodologies frequently used in ABA-based programs. DTT and ABA are not synonymous. DTT is an

Autism is often characterized by minimal emotional attachment; gross and sustained impairment of reciprocal social interaction; absent or abnormal speech; retarded intelligence quotient (IQ); restricted, repetitive, ritualistic, and stereotyped patterns of behavior, interests, and activities; aggression; and/or self-injury. As a "spectrum disorder," some but not all of these characteristics may be present.

intensive early intervention program for children three to five years old that addresses all developmental domains (language skills, motor skills, etc.).

DTT is presented in an intensive on-to-one "training trial" format. A discrete trial is a single cycle of a behaviorally-based instruction routine. A particular trial may be repeated several times in succession, several times a day, over several days (or even longer) until the skill is mastered. The training environment should be free of distractions for controlled stimulus-response, repetition, and memory imprinting. Each training trial, regardless of the skill objective, consists of four major components:

- The teacher or therapist presents a brief, distinctive instruction or question (stimulus). The instruction is followed by a prompt, if the child needs one, to elicit the correct response.
- The child responds correctly or incorrectly (response).
- The teacher or therapist provides an appropriate "consequence." Correct responses receive a reward, which may be an edible treat, a toy, hugs or praise; incorrect responses are ignored and/or corrected.
- Data are recorded.

Research has established that less-than-intensive training has generally been unsuccessful. Generally, successful efforts have followed the Lovaas approach of administering this intensive therapy for an average of 40 hours per week for two or more years.

6. Behavior modification (BMOD) is another of the instructional methodologies used in ABA-based programs. BMOD is not DTT, although DTT contains a behavioral modification component. Rather than teaching a specific skill, BMOD focuses on increasing positive behaviors and decreasing maladjustive behaviors. Dr. Moradi used the example of brushing teeth to distinguish DTT from BMOD. In her example, DTT would be used to develop the skills required for brushing teeth. BMOD could later be used to address a child's refusal to brush his or her teeth. Whereas DTT could be used to teach a child to stop on command or signal, BMOD would address behaviors such as self-injurious eye-poking or the tendency to run away.

There is no time or age limit for effective application BMOD.

7. Separate and distinct from DTT and BMOD is the need for an older child to be able to generalize and integrate into the community the early intervention skills addressed by DTT and the ongoing application of BMOD. The goal is for the child to be able to apply skills and behave appropriately in different environments

8. Claimant's initial Individual Program Plan (IPP) was prepared in January 2003. Under the IPP, the service agency was to provide various services, including funding of in-home DTT from July 1, 2003 to November 30, 2003, at the rate of six (6) hours per week and up to 24 hours per month.

9. Behavior Health Consultants L.L.C. (BHC), was the service agency vendor that had been delivering discrete trial training services to claimant. BHC prepared periodic DTT progress reports, a DTT transition plan, and a Summary and Recommendation, which the vendor provided to the service agency.

10. In its November 2003 Discrete Trials Training Progress Report / Request for Re-Authorization of Services, which covered the five-month assessment period from June 1, 2003 to October 31, 2003 (a total of 119.25 hours and 60 sessions), BHC noted that although claimant had made excellent progress in his programs, his non-compliant behaviors had increased and there were many goals that still needed to be met for claimant to develop age appropriate skills. BHC recommended that "DTT be continued at 6 hours per week for the next six months."

11. In its April 2004 Discrete Trials Training Progress Report / Request for Re-Authorization of Services, which covered the four-month assessment period from December 1, 2003 to April 24, 2004 (a total of 118.5 hours and 58 sessions), BHC noted that claimant again made excellent progress in his DTT program. However, claimants non-compliant and "feces smearing" behaviors continued to undermine his full potential. BHC made two recommendations. First, if claimant showed no improvement in these behaviors in three months, then the service agency should consider funding three months/ 36 hours of behavioral intervention. Second, the service agency should "authorize six hours of DTT per week spread out over a four-month period" and two hours of DTT supervision per month.

12. In its August 2004 Discrete Trial Training Progress Report, which covered the three-month assessment period from June 1, 2004 to August 21, 2004 (a total of 68 hours and 33 sessions), BHC noted that claimant had decreased his inappropriate behaviors and improved his toileting skills, but "continues to need DTT services to further focus on communication, socialization, and self-help skills." BHC recommended that the service agency "authorize six hours of DTT per week spread out over a three-month period" and two hours of DTT supervision per month.

In September, BHC provided a second progress report covering the same assessment period. The second report duplicated the first, except that BHC recommended funding for two and one-half hours of DTT supervision per month. The vendor did not provide a reason for the additional half-hour of supervision.

13. In September 2004, claimant's IPP was amended to provide for continued services of "intensive" behavior modification in the home. The delivery of this service was to remain at six hours per week for the period October 1, 2004 to March 31, 2005. The reason for the amendment was to reduce claimant's inappropriate behaviors, improve his adaptive functioning, and increase his attention span, frustration tolerance, impulse control, and social interaction skills.

14. The last annual review of claimant's IPP, prior to the administrative hearing, was held on February 17, 2005. Under the section "Progress on IPP Outcomes," the IPP stated: "Adam will continue to receive Discrete Trial Training to decrease the frequency of wandering off and of placing himself in dangerous situations." The IPP also noted that claimant lacks safety awareness and his mother "is overwhelmed by the amount of time and energy she must spend with Adam to keep him focused."

15. In its February 2005 Discrete Trials Training Progress Report, which covered the four-month assessment period from October 1, 2004 to February 23, 2005 (a total of 118 hours in 58 sessions), BHC noted that claimant continued to show progress in the targeted areas but still needed further work on communication, socialization, and self-help skills. Although claimant's aggression, non-compliant behavior, and verbal self-stimulations had remained constant, his tantrums had decreased and BHC planned to implement a new behavioral intervention plan to decrease his non-compliance. BHC recommended that the service agency "re-authorize six (6) hours of DTT per week spread out over a three-month period" and two (2) hours of DTT supervision per month.

16. As documented in a service agency transaction note dated March 8, 2005, Dr. Johnson reviewed BHC's February 2005 report and concluded that claimant had received one-to-one DTT services for a period of four years and, as indicated in BHC's February 2005 report, claimant's maladaptive behaviors had remained essentially unchanged. She concluded that continued DTT was contraindicated and that claimant should be transitioned into a social skills training program. She suggested that DTT be faded-out during the next six months.

17. On April 16, 2005, BHC submitted a Discrete Trials Training Transition Plan. The plan presented target goals for three levels of intervention: six hours per week, four hours per week, and "ongoing" six hours per month. Although BHC noted that claimant still had outstanding developmental needs in the areas of communication, socialization, and self-help skills, the vendor recommended that six hours per week of DTT continue from July 1, 2005 through August 31, 2005, and then be reduced to four hours per week from September 1, 2005, through December 31, 2005. BHC did not provide any rationale for the decision to decrease the amount of intervention services. Apparently, the proposed reduction was in response to the recommendation that Dr. Johnson made after her review of BHC's February 2005 progress report.

18. As documented in a service agency transaction note dated May 4, 2005, Dr. Johnson reviewed BHC's DTT Transition Plan and concluded that it was not adequate, in that it did not allocate sufficient DTT hours to parent training, implementation, and feedback.

19. Claimant's mother became aware that the service agency was considering reducing claimant's DTT hours and, on May 6, 2005, she sent an e-mail message to Jessye Davis, wherein claimant's mother reminded Ms. Davis that they had previously agreed to add one and one-half hours of social skills therapy per week in exchange for

reducing two hours of claimant's "weekly ABA." Claimant's mother asked the service agency to delay the reduction in DTT hours because BHC had hired a new supervisor who was using new techniques with claimant that had exceptional results. She could not, in good conscience, agree to cut claimant's ABA hours during the summer.

20. On May 11, 2005, claimant's mother called Dr. Johnson to express her concerns regarding reduction of intervention hours, and request a meeting. Dr. Johnson asked claimant's mother to communicate through the service coordinator or regional manager. Dr. Johnson told Mr. Suzuki about claimant's mother's request for a meeting.

21. In its May 2005 Discrete Trials Training Progress Report, which covered the assessment period from April 1, 2005 to May 14, 2005 (a total of 40 hours in 18 sessions), BHC noted that claimant's aggression and non-compliant behavior had worsened and, although the periodicity of tantrums had decreased, their intensity had increased. Again, the vendor recommended that the service agency re-authorize six (6) hours of DTT per week, for a three-month period, and two and one-half hours of DTT supervision per month.

22. On May 26, 2005, the FDLRC staff and consultants held a clinical review staffing meeting to discuss a "fade-out" plan for claimant's DTT. Participants included Dr. Johnson, Dr. Moradi, Sam Suzuki, Jessye Davis, Wendy Leskiw, M.D., Avo Yetenekian, Ph.D, and Gwendolyn Jordan, RN. Except for Ms. Davis, none of the other participants had ever met claimant. In spite of claimant's mother's earlier request to delay the reduction in DTT hours and to have a meeting with her, claimant's parents were not notified or invited to the meeting.³

At this meeting, Dr. Johnson and Dr. Moradi primarily relied on BHC's progress reports to form the basis for their recommendation that claimant's DTT services should be phased out.⁴ The participants proposed that claimant receive four (4) hours of behavioral support per week, instead of six hours, beginning July 1, 2005. Services would be reviewed every three months. The participants also noted that it was imperative that claimant's parents learn to address and correct claimant's maladaptive behaviors in the absence of a 1:1 interventionist. They agreed that, given claimant's age and functioning level, it would be more appropriate for him to have greater opportunities to apply his previously learned skills.

23. Based on the recommendations from the May 26, 2005, clinical review meeting, the service agency prepared a Notice of Proposed Action and a related letter, both dated May 31, 2005, which the service agency sent to claimant's parents. The notice and letter informed claimant's parents that "the hours of DTT services with BHC will be

³ As early as May 17, 2005, the service coordinator and regional manager scheduled this clinical review staffing meeting.

⁴ BHC's May 2005 Progress Report had not been reviewed by the meeting participants.

reduced from 6 hours to four hours per week from July 1, 2005, and will be evaluated in September 2005 for documented progress and his success in other programming."

The letter, which was signed by Jessye Davis and Sam Suzuki, noted that claimant had made significant progress both at school and at home with BMOD and DTT services, but that BHC's progress report of February 2005 noted that claimant's "rates of maladaptive behavior were essentially unchanged over the previous period."

The Service Agency's Notice of Proposed Action included a section entitled Right to Appeal, which contained the following statement in boldface type:

Your services will continue during the appeal process if your request for a fair hearing is postmarked or received by the regional center or state development center, whichever is earlier, no later than 10 days after receiving this notice.

The letter that was attached to the notice also advised claimant's parents that since claimant was currently receiving DTT services, "if you wish the services to continue at the desired level until the end of the appeal process you must return your request for a fair hearing within ten (10) days of receipt of this letter."

24. Claimant's parents received the Notice of Proposed Action and attached letter on June 3, 2005.

25. Claimant's mother disagreed with the service agency's plan and on June 21, 2005, hand-delivered a Fair Hearing Request to the service agency to appeal the decision to reduce claimant's "ABA" hours. Since the service agency received the Fair Hearing Request more than 10 days after claimant's parents received the Notice of Proposed Action, the service agency reduced claimant's funded DTT services to four hours, effective July 1, 2005. This hearing ensued.

26. In its September 2005 Discrete Trials Training Progress Report, which covered the three-month assessment period from June 1, 2005 to September 3, 2005 (a total of 50 hours in 24 sessions), BHC reported that although claimant continued to show improvement in his DTT programs, his inappropriate behaviors had increased. BHC noted that all or part of that increase may have been related to an anti-seizure medication that claimant had started taking. BHC recommended continuation of DTT interventions at the rate of four (4) hours per week and DTT supervision at two (2) hours per month for the next two months.

27. On October 25, 2005, claimant's father approved an IPP amendment for claimant to receive discrete trial training at the rate of four (4) hours per week for the period October 1, 2005 to November 30, 2005. The service agency recommended two months of service, pending revision of claimant's IPP objectives.

28. In November 2005, BHC prepared a Discrete Trials Training/Behavioral Intervention Report that covered the three-month assessment period from September 4, 2005 to November 26, 2005 (a total of 48 hours in 24 sessions). BHC reported that claimant's inappropriate behaviors had continued to be maintained as he was being weaned from his anti-seizure medication. BHC again recommended re-authorization of continued DTT interventions at the rate of four (4) hours per week and DTT supervision at two (2) hours per month for the next three months.

29. On January 12, 2006, BHC prepared a Summary and Recommendation report that the vendor sent by facsimile to the service agency. Approximately five and one-half hours after the initial transmission, BHC transmitted a replacement for the third page of the report. The replacement page changed the vendor's recommended rate for behavioral intervention in the home and community, reducing it from six to four hours per week.

The report acknowledged that although claimant continued to experience social, behavioral and communication deficits, "DTT is probably not the best 'plan of action' at this time." Instead, BHC proposed implementing a Behavioral Intervention program using the current BHC staff. The program would include intensive instruction and practice for claimant's mother in implementing a behavior modification program.

30. The service agency had been funding "DTT" based on claimant's January 2003 IPP and October 2005 IPP amendment. The BHC reports were supposed to address DTT progress. However, in a strict sense, that is not the service that BHC had provided to claimant. Instead, the vendor had been using an ABA-mix of DTT and BMOD interventions.

31. As was emphatically noted by Dr. Moradi, BHC's reports left much to be desired. As an evaluation, analysis, and assessment tool, they were of little value. The reports did not quantitatively describe claimant's baseline, the specific interventions used, and how the outcomes quantitatively varied from claimant's baseline. In uniform fashion, the reports emphasized claimant's parent's satisfaction with the vendor and the need to continue authorizing services. The reports only conveyed a generic sense of progress.

32. Dr. Jean Johnson has a doctorate degree in speech-hearing sciences. She opined that DTT was no longer appropriate and that claimant's program should now focus on parent training and addressing the maladaptive behaviors that occurred in the home when the BHC therapist is not present. She emphasized the need for claimant to be able to generalize use of DTT-derived skills in environments where the agent/therapist is not present. Dr. Johnson's perspective was based on her belief that for a period of three to four years claimant had been receiving the "early-intervention" DTT.

///

33. Dr. Griesbach is a physician who specializes in developmental pediatrics. Claimant's parents had Dr. Griesbach evaluate claimant in February - March 2005 for the purpose of assistance, guidance, and coordination in the further treatment of claimant. She described claimant as bright, savant, at or near grade level with good cognitive strengths, and having much potential for relative/partial independence as an adult. However, claimant's repetitive, perseverative, avoidance behaviors and toilet training needed to be directed all the time, as if claimant was a lower-functioning child. In her letter dated January 9, 2006, Dr. Griesbach stated:

. . . Adam is receiving grossly insufficient ABA service at this time given his extraordinary needs and his potential. Given Adam's cognitive, academic and musical strengths, he has the potential to be much more independent and self sufficient, but this cannot happen without appropriate intervention. Adam's atypical behaviors cannot be addressed adequately so that he can modify his behaviors long term. . . .

Therapeutically, at this time, Adam requires treatment with ABA/DTT **15 hours per week** in order to adequately eliminate self-injurious behaviors that could lead to blindness; bolting behaviors that could lead to serious injury as he runs away even when out on the street in the community; and physical acting out behaviors that could cause injury to others now that he is older and bigger. In addition, the therapy will facilitate development of more appropriate functional behaviors that will allow him to remain in mainstream education and community settings rather than ultimately restricting him from these activities as he gets older and larger. More consistent and frequent therapy will allow him to develop the behaviors necessary for eliminating on the toilet so that he can stop wearing pull-ups and so that he can be more socially appropriate. [Emphasis in original.]

Dr. Griesbach testified that claimant's inappropriate behaviors need to be modified or he would be relegated to a narrower life-style. She testified that 15 hours per week of continued ABA / behavior modification services (two-to-three hours per day, six days a week), in in-home and community settings where claimant loses self-control, will provide sufficient frequency and intensity to address these concerns.

34. Claimant also provided a letter from Bhavik G. Shah, M.D., an associate clinical professor of psychiatry at the David Geffen School of Medicine, University of California, Los Angeles. Dr. Shah is a neurologist who had worked with claimant since he was five years old. In his letter, Dr. Shah merely stated: "Ten hours of ABA would be beneficial to improving [claimant's] ability to become an independent citizen."

35. Based on the recommendations of claimant's experts, claimant decided to ask for service agency funding of 10 hours of ABA per week.

36. Dr. Moradi presented the most coherent and reasoned explanation for the processes that should be followed in assessing claimant's needs. She testified that in her opinion, rather than focusing on DTT or BMOD, the goal of claimant's program should be the generalization of learned DTT skills through a community integration plan. Admittedly, Dr. Moradi had never evaluated claimant. But it was her understanding that claimant had received two years of DTT⁵ and it would be "contraindicated" for DTT to be continued indefinitely.

Of particular concern to Dr. Moradi was the fact that the service agency did not have a current baseline for claimant. The reason that the service agency did not have a baseline was due to the nature of BHC's progress reports, in that they did not contain the details needed for a proper assessment, including prioritized, defined, objectively measurable goals; specific information regarding what methods would be implemented and by whom; and how funded hours would be used, i.e., how much and for what specific purpose. What was needed for decisionmaking, but not provided, were progress reports that included a quantitative comparison of claimant's baseline and demonstrated progress. Such documentation was not available before the service agency's May 2005 clinical review and it still remains a significant gap in knowledge about claimant.

Dr. Moradi opined that due to the lack of a baseline, the proper approach would be to (1) do a functional analysis of respondent's behavior, (2) identify and prioritize behaviors that needed to be addressed, (3) develop a plan that includes the best method to address each inappropriate behavior, and (4) implement the plan, in conjunction with the parent, to insure consistent interventions. In rare instances where claimant continued to be non-responsive to his parents, alternative methods would be used and, if they all proved unsuccessful, an alternative would be used that did not require parental intervention.

37. The reporting shortfalls that were characteristic of BHC's progress reports also applied to the recommendations from the service agency and claimant's experts. They did not present, or lacked the details, needed to support their conclusions. The service agency presented no quantitative basis for determining claimant's behavioral needs and how to address those needs.

38. Claimant's mother has been an active advocate for claimant and had received parent training through a few workshops and conferences. She also observed BHC's interventions with claimant.

39. The service agency applied two internal policy guidelines in determining what services would be appropriate for claimant. The first policy guideline was the

⁵ No evidence was presented to establish that claimant had received one or more years of "intense" DTT, as described in Factual Finding 5. Claimant's mother testified that claimant never received "pure" DTT services at the research-based recommended intensity of 40 hours per week.

Funding Guidelines for Intensive Intervention Services for Children with Autism Spectrum Disorders, which states, in relevant part:

Intervention which addresses the individual and intensive needs of the child with an Autism Spectrum Disorder is funded under the following guidelines:

1. Before any ongoing service is authorized, it must be supported by an assessment from a professional trained in that discipline.

2. The combination of services and service intensities will be recommended by the Interdisciplinary Team developing the IFSP^[6] and agreed upon by the parent . . . and regional center pursuant to the California Early Intervention Services Act.

3. Parents must demonstrate the willingness and the capacity to participate in interventions as directed by the service provider(s).

[¶] . . . [¶]

5. Individual funding authorizations will not exceed four months. All programs will be reviewed to monitor progress relative to goals listed in the IFSP and to assure the appropriateness of interventions. . . .

6. For children aged three and above, the local education agency is considered to be the primary provider for education and related services as a part of the client's primary program. All services for children older than three years of age may be authorized as an exception to policy.

40. The second internal policy guideline the service agency applied in determining what services would be appropriate for claimant is the Behavior Management Funding Guidelines, which prioritizes funding for various available behavior management services. It states, in relevant part:

Behavior management services may be explored and funded for families in the following priority order:

1. Community-based classes, groups, and trainings in parenting, and basic behavioral techniques

2. Behavior Management and Parenting Support Network

3. Group Format . . . periodic group parent training to meet general basic information needs. . . .

4. Individual Format: Behaviors that are more extreme due to their frequency, severity, or intensity, those that endanger a client's home/work/day program placement, or present a danger to the client or others may be referred to an appropriate service provider for assessment and intervention on an individual basis. Unless such service is to assist staff in level two or three homes, such interventions will be approved only by exception to policy. When individual intervention is the chosen modality, a finding must be made that the

⁶ An Individual Family Support Plan (IFSP) is applicable to consumers up to age three, and an Individual Program Plan (IPP) for older consumers. After claimant was three years old, all legal requirements of an IPP applied.

parent . . . is motivated to learn these skills, and capable of carrying out the behavior intervention plan.

Services provided via the individual format are typically funded for 36 hours over a three-month intervention period. Requests for additional services are an exception to policy and will be considered with respect to documented progress on specified objectives, and will necessitate the successful and continued participation of the parent and/or caregiver. The Regional Center consulting psychologist will review all requests for service as well as progress reports at three-month intervals to determine that the program is effective and continuation is necessary to achieve the goals and objectives as delineated in the IPP.

LEGAL CONCLUSIONS

1. The standard of proof in this proceeding is that of a preponderance of the evidence. (Evid. Code, § 115.)

2. Except as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that the party is asserting. (Evid. Code, § 500.) Where a claimant seeks to establish eligibility for government benefits or services not previously funded, the burden of proof is on him. (See, e.g., *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 (disability benefits); *Greator v. Board of Admin.* (1979) 91 Cal.App.3d 54, 57 (retirement benefits). However, a service agency seeking to change a service previously provided to a claimant has the burden to demonstrate its decision is correct.

In this case, both claimant and the service agency are seeking changes in the amount of ABA/DTT services funded by the service agency. Therefore, the service agency has the burden of establishing by a preponderance of the evidence that funding for claimant's ABA/DTT therapy should be reduced from six to four hours per week. Claimant has the burden of establishing that the service agency should fund up to 10 hours of ABA/DTT therapy per week and/or that claimant is entitled to receive compensatory hours of ABA/DTT therapy based on the reduction in hours implemented in July 2005.

3. The service agency must provide services to meet its obligations under the Welfare and Institutions Code. Welfare and Institutions Code section 4501 states, in pertinent part:

The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge. . . . A consumer of services and supports, and where

appropriate, his or her parents, legal guardian, or conservator, shall have a leadership role in service design.

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community. . . .

Services and supports should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age. Consumers of services and supports, and where appropriate, their parents, legal guardian, or conservator, should be empowered to make choices in all life areas.

. . . It is the intent of the Legislature that agencies serving persons with developmental disabilities shall produce evidence that their services have resulted in consumer or family empowerment and in more independent, productive, and normal lives for the persons served.

4. Welfare and Institutions Code section 4502.1 states:

The right of individuals with developmental disabilities to make choices in their own lives requires that all public or private agencies receiving state funds for the purpose of serving persons with developmental disabilities, including, but not limited to, regional centers, shall respect the choices made by consumers or, where appropriate, their parents, legal guardian, or conservator. Those public or private agencies shall provide consumers with opportunities to exercise decisionmaking skills in any aspect of day-to-day living and shall provide consumers with relevant information in an understandable form to aid the consumer in making his or her choice.

5. Welfare and Institutions Code section 4512, subdivision (b) states, in pertinent part:

Services and supports for persons with developmental disabilities' means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. **The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process.** The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and **shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each**

option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. . . . Nothing in this subdivision is intended to expand or authorize a new or different service or support for any consumer unless that service or support is contained in his or her individual program plan." (Emphasis added.)

6. Welfare and Institutions Code section 4646 states, in pertinent part:

(a) It is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, where appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and healthy environments. It is the further intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources.

(b) The individual program plan is developed through a process of individualized needs determination. The individual with developmental disabilities and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, shall have the opportunity to actively participate in the development of the plan.

[¶] . . . [¶]

(d) Individual program plans shall be prepared jointly by the planning team. Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the consumer's individual program plan and purchased by the regional center or obtained from generic agencies shall be made by agreement between the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative at the program plan meeting.

[¶] . . . [¶]

(g) An authorized representative of the regional center and the consumer or, where appropriate, his or her parents, legal guardian, or conservator, shall sign the individual program plan prior to its implementation. . . .

7. Welfare and Institutions Code section 4648, states, in pertinent part:

In order to achieve the stated objectives of a consumer's individual program plan, the regional center shall conduct activities including, but not limited to, all of the following:

(a) Securing needed services and supports.

(1) It is the intent of the Legislature that services and supports assist individuals with developmental disabilities in achieving the greatest self-sufficiency possible and in exercising personal choices. The regional center shall secure services and supports that meet the needs of the consumer, as determined in the consumer's individual program plan, and within the context of the individual program plan

8. Welfare and Institutions Code section 4659, subdivision (a) states, in pertinent part:

[T]he regional center shall identify and pursue all possible sources of funding for consumers receiving regional center services. These sources shall include, but not be limited to, both of the following:

(1) Governmental or other entities or programs required to provide or pay the cost of providing services, including . . . **school districts**
[Emphasis added.]

Thus, when a generic agency fails or refuses to provide a service agency consumer with those supports and services that are needed to allow that consumer to maximize his potential for a normal life, the Lanterman Act requires the service agency to make up the service shortfall.

9. Consistent with the legislature's position that children with developmental disabilities most often have greater opportunities for educational and social growth when they live with their families, under Welfare and Institutions Code section 4685, subdivision (b), regional centers are to provide or secure family support services that "respect and support the decisionmaking authority of the family" and are "flexible and creative in meeting the unique and individual needs of families as they evolve over time."

10. The dispute in this case is over how much service agency funded ABA/DTT services is claimant is entitled to receive each week to meet the goals of the Lanterman Act and claimant's needs, as set forth in his IPP. Consideration is to be given to the preferences of claimant's parents, the cost-effectiveness of the therapy, and generic funding sources.

11. Claimant's initial IPP provided for six hours of DTT per week, up to 24 hours per month. The service agency should have known, as set forth above in Factual Finding 5, that if the intent was to provide effective DTT services for claimant, six hours per week would not be sufficient. Additionally, as indicated by Dr. Moradi and claimant's mother, intensive DTT was not what the vendor provided. The service agency received periodic reports from BHC. Any concerns that the service agency may have had regarding the types of ABA services the vendor was providing to claimant should have been addressed early-on. However, the only issue raised by the service agency was the number of hours it had to fund. Since the service agency knew that some form of ABA

was provided by the vendor, as opposed to “pure” DTT, it would be inappropriate for the service agency to base any decisions on an understanding that the present issue should focus only on “DTT” funding, as opposed to generic ABA funding.

12. From the standpoint of claimant’s IPP, when claimant’s father and the service agency signed the October 2005 IPP amendment, they agreed to a reduction in claimant’s DTT services, from six to four hours per week, for the period October 1 through November 30, 2005, pending revision of claimant’s IPP objectives. No IPP amendments subsequent to October 2005 were offered by either party to support a further change in claimant’s DTT service hours or to indicate that claimant’s IPP objectives were revised.

13. Although claimant’s IPP was amended to provide for only four hours of ABA/DTT per week, the Administrative Law Judge also finds that the service agency did not establish that four hours of ABA/DTT are adequate to meet claimant’s unique needs. (Factual Findings 3 through 8, 17 through 23, 26 through 34, 36, 37, 39 and 40; Legal Conclusions 3 through 12.)

14. The crux of the problem is that the service agency proposed a modification of claimant’s services based on inadequate information and/or a misconception regarding the type of service provided to claimant by BHC. Dr. Johnson was under the impression that claimant was receiving intensive DTT, when that was not the case. However, it was her assessment and recommendation that was adopted during the May 2005 clinical review meeting. Claimant’s parents opposed the reduction in services and countered with a request for a significant increase in ABA. Claimant’s parents based their request on their own observations and the recommendations of Dr. Shah, claimant’s neurologist, and Dr. Griesbach, a pediatrician.

Claimant’s mother and Dr. Griesbach identified specific behaviors that need to be addressed. But neither Dr. Griesbach nor the service agency’s experts offered a specific approach to address these problems. Accordingly, the Administrative Law Judge has insufficient information to determine how many hours of ABA services should be funded by the service agency to meet claimant’s needs.

15. Welfare and Institutions Code section 4710, subdivision (a) states, in pertinent part:

Adequate notice shall be sent to the applicant or recipient and the authorized representative, if any, by certified mail at least 30 days prior to any of the following actions:

(1) The agency makes a decision without the mutual consent of the service recipient or authorized representative to reduce, terminate, or change services set forth in an individual program plan.

///

16. Welfare and Institutions Code section 4715, subdivision (a) states, in pertinent part:

(a) Except as otherwise provided in this section, if a request for a hearing is postmarked or received by the service agency no later than 10 days after receipt of the notice of the proposed action mailed pursuant to subdivision (a) of Section 4710, services that are being provided pursuant to a recipient's individual program plan shall be continued during the appeal procedure up to and including the 10th day after receipt of any of the following:

¶ . . . ¶

(3) Receipt by the recipient of the final decision of the hearing officer or single stage agency pursuant to subdivisions (a) and (c) of Section 4712.5.

17. The Administrative Law judge finds that the service agency provided adequate notice to claimant's parents regarding the need to request a fair hearing no later than 10 days after their receipt of the Notice of Proposed Action regarding the reduction in claimant's ABA/DTT hours. Since claimant's parents did not request a hearing until after 10 days had elapsed, the service agency was authorized to reduce the hours of ABA/DTT to four hours per week, pending resolution of this matter. (Factual Findings 22 through 25; Legal Conclusions 15 and 16.)

18. Although Welfare and Institutions Code section 4710 applies to claimant's mother's late submission of her Fair Hearing Request, the Administrative Law Judge understands that regional centers routinely exercise discretion in the form of leniency when applying the provisions of section 4710. However, even if claimant's parents filed their Fair Hearing Request within the 10 days allotted by section 4710, claimant's ABA/DTT services would still have been reduced from six to four hours, at least temporarily, subject to claimant's October 2005 IPP amendment. The Administrative Law Judge finds that based on the entire record there is no basis for awarding compensatory hours for ABA/DTT services to claimant.

19. In matters such as this, the letter of the law should be tempered with the spirit of the law. The fact that the service agency made decisions without adequate information, the fact that claimant still has maladaptive behaviors that must be addressed, and the fact that claimant's mother's May 2005 request for a meeting was not honored, the Administrative Law Judge finds that, claimant's ABA/DTT hours should immediately be funded at the rate of no less than six hours per week, pending completion of a functional assessment and follow-up IPP meeting. The format for delivery of the ABA/DTT (i.e., DTT, BMOD, or another method) will be based on consultation between the service agency, BHC, and claimant's parents, but will focus on those maladaptive behaviors that are of greatest concern to claimant's parents. Up to two of the six hours per week of ABA/DTT services may be allocated to parent training that addresses those maladaptive behaviors. This level of ABA/DTT services should continue until the

functional assessment is completed and claimant's IPP is amended/revised to incorporate the results thereof, or the service agency and claimant's parents otherwise agree to a different level of such services.

20. As indicated by Dr. Moradi, the appropriate first step in the needs-identification process is a functional assessment. Although Dr. Griesbach and claimant's mother have identified maladjustive behaviors that need to be addressed, a functional assessment of claimant is needed to measure the level or degree of independence, amount of assistance required, and safety considerations for a variety of categories, including activities of daily living, communication skills, and psychosocial adjustment.

Once the results of the functional assessment is obtained and reviewed by the service agency and claimant's parents, an IPP meeting should be convened to accomplish the following:

- a. Identify claimant's specific maladaptive behaviors that need to be addressed.
- b. Prioritize the maladaptive behaviors, with consideration of claimant's parent's preferences.
- c. Develop an intervention for each maladaptive behavior. The plan must include, as a minimum:
 - (1) Quantitative/measurable goals and objectives.
 - (2) How each maladaptive behavior will be addressed, including consideration of both direct intervention methods and parent training.
 - (3) Who shall have responsibility for providing the services (i.e., the service agency, claimant's parents, and generic resources, including claimant's school district).
 - (4) Monitoring, reporting, and reassessment criteria.

21. Generic resources must be considered in this case. This is because regardless of entitlement to services and support, a service agency is precluded from using its funds to provide the requisite services and support, if, in so doing, it would *supplant* the budget of any other agency which has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services. (Welf. & Inst. Code, § 4648(a)(8).)

22. Since claimant is school-aged and in the third grade, for purposes of Welfare and Institutions Code section 4648(a)(8), claimant's school district is a generic resource not only for those aspects of education that traditionally occur in a classroom, but also extend into the home setting, where academic skills are merged with other learning experiences.

ABA has both social and academic components, and the two often overlap. The language of the Lanterman Act makes clear that, should a generic agency such as a school district fail or refuse to provide a service agency with those supports and services that are needed to allow that person to maximize their potential for a normal life, the service center is required to make up for the service shortfall.

Beyond the classroom environment, all other learning domains are, at least potentially, areas in which the Lanterman Act may require regional centers to provide their consumers with needed supports and services.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant Adam W.'s request for service agency funding of up to 10 hours per week of direct intervention applied behavior analysis/discrete trial training is GRANTED in part and DENIED in part, as follows:

1. The service agency shall immediately resume funding of “applied behavior analysis” at a rate not less than six (6) hours per week, inclusive of up to two (2) hours per week allocated to parent training.

2. The service agency shall schedule, and claimant's parents will make reasonable accommodation for, a functional assessment of claimant to determine his current developmental status, with emphasis on identifying maladaptive behaviors. The assessment shall be scheduled no later than 60 days from the date of this Decision.

3. No later than 30 days following the completion of claimant’s functional assessment, the service agency will schedule an IPP meeting to accomplish the following:

- a. Identify claimant’s specific maladaptive behaviors that need to be addressed.
- b. Prioritize the maladaptive behaviors, with consideration of claimant’s parent’s preferences.
- c. Develop an intervention for each maladaptive behavior. The plan must include, as a minimum:
 - (1) Quantitative/measurable goals and objectives.
 - (2) How each maladaptive behavior will be addressed, including consideration of both direct intervention methods and parent training.
 - (3) Who shall have responsibility for providing the services (i.e., the service agency, claimant’s parents, and generic resources, including claimant’s school district).
 - (4) Monitoring, reporting, and reassessment criteria.

///

///

///

///

4. Claimant's request for service agency funding of compensatory ABA/DTT hours for the period from July 2005 to the present is denied.

This is a final administrative decision, each party shall be bound by this decision. Either party may appeal the decision to a court of competent jurisdiction with 90 days of receiving notice of the final decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)

May 14, 2005.

ROBERT S. EISMAN
Administrative Law Judge
Office of Administrative Hearings